TECHNIQUE

The bone graft is harvested and morcellised. A standard plastic hypodermic syringe is now chosen. The syringe size depends upon the size of the lesion. Usually, for arthroscopic techniques, we use a 1-ml syringe. In open surgery, a larger syringe can be used. The needle end of the syringe is removed using a sharp scalpel blade and the syringe is manually loaded with the bone graft with the plunger pulled back (Fig 1). The syringe is introduced using the arthroscopic portal or open joint access. Using the syringe plunger, the bone graft is delivered into the desired area. The same technique is used to deliver antibiotic pellets into bone voids or into the medullary canal in the treatment of infection.

DISCUSSION

This technique is simple, effective, and customisable depending on the void. It allows targeted delivery of a measurable amount of bone graft with no wastage. The technique can be used in other small joints and in endoscopic surgery. A similar technique has been previously described in knee surgery.¹

Reference

1. Espinoza C, Ellis HB, Wilson P. Arthroscopic delivery of cancellous tibial autograft for unstable osteochondral lesions in the adolescent knee. *Arthrosc Tech* 2014; **3**(3): e339–e342.

Prevention of iatrogenic chemical burns during tourniquet controlled hand surgery

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Chemical burns secondary to skin preparations leaking beneath a pneumatic tourniquet are a rare but significant iatrogenic complication.¹ We outline a simple technique to prevent this injury, particularly during surgery where exposure of the elbow area below a tourniquet is required. Additional surgical wool is looped just below the distal end of the tourniquet (Figs 1a and 1b) to prevent leakage of preparation. The wool is removed prior to tourniquet inflation, leaving a narrow area free from preparation (Figs 1c and 1d). We have observed no complications using this technique, and it is a simple and effective alternative to commercially available tourniquet drapes.

Figure 1 Stepwise application of wool tourniquet protector for cubital tunnel surgery

Reference

1. Dickinson JC, Bailey BN. Chemical burns beneath tourniquets. *BMJ* 1988; **297**: 1,513.

Management of laser fibre during ureterorenoscopy and laser lithotripsy

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BACKGROUND

Laser lithotripsy of calculi in the urinary tract is a well-established treatment modality for calculi in all parts of the urinary tract. Laser fibres are necessarily long (200 cm) to reach between the laser machine and the end of the ureteroscope. The disadvantage of this length is the potential for the fibre to touch nonsterile surfaces, thus requiring replacement at significant cost.

Figure 1 Fibre lying over patient's leg with damp swab

Figure 2 Fibre sheath attached to leg drape with fibre in place